to be —2.5 and the horizontal +2.5. This can be corrected either with +2.50 sph.⊂⊃ —5 cy. ax. 180 or —2.50 sph.⊂⊃ +5 cy. ax. 90. Clearly the latter will allow greater lateral range, the concave surface being next to the eye. If the vertical field should be the more important, which would be very unusual, the first formula is to be used. In compound astigmatism a concave spherical surface must be on one side, in which case the requisite toric or compound astigmatic surface is to be ground on the other. This adds very materially to the expense.

[The same author remarks in a paper published elsewhere that the glasses commonly sold as periscopic are hardly worthy of the name.]

Monolateral Innervation of the Occipitofrontalis in a Case of Complete Bilateral Paralysis of the Oculomotor Nerves.—SALOMONSOHN (*Berlin. klin. Wochenschrift*, 1901, No. 26) reports the case of a man, aged forty-nine years, without distinct specific history, but given to the abuse of alcohol, who began to have double images April of last year, with pain starting in the left eye. No definite diagnosis was then possible, although both pupils, moderately dilated (4 mm.), were insensitive to light. Decided though slight reaction to convergence, especially on the left side, was present. Accommodation on both sides paretic. Visual acuity, fields and ophthalmoscopic appearances continued normal throughout. Two weeks later there developed a typical total paralysis of the left oculomotor nerve (complete ptosis, external strabismus, eyeball movable only by the external rectus, and rotation by the trochlearis). The patient was elsewhere subjected to five weeks' inunction treatment with gray ointment without the slightest result. In the beginning of August the right eye was found to be affected with paralysis of the internal, inferior, and superior recti, paresis of the inferior oblique, beginning ptosis, complete bilateral paralysis of accommodation. The paralysis of the oculomotor soon became total on this side also. Pupils absolutely fixed (convergence no longer possible). On both sides slight exophthalmus paralyticus. Condition thus far unimproved by potassium iodide. The patient complained of a permanent dull feeling in the face without objective signs of trigeminus involvement. Sense of taste for all substances abolished. Everything tasted disgustingly sweet, even when the various substances were diffused in the mouth and not permitted to touch the tongue only—solutions of salt, sugar, acetic acid, quinine. Marked disturbance of the olfactory nerve. Ol. terebinth., ol. menth. pip., ol. caryoph., tr. asafœt. not distinguished. Sal. ammoniac at once recognized in consequence of the irritation of the trigeminus. Gait, as to be expected, uncertain, but not ataxic. No swaying upon closure of the eyes. Patellar reflex present. No tremor of the hands. Tongue protruded straight. No disturbances of speech or deglutition. Facial nerves normal on both sides. Internal organs healthy, urine normal. Latterly the patient complains of headache, presents psychical changes, is often absent-minded, and forgets what he wants to do. Remembers the past well, but not recent events, and makes strange mistakes.

The writer remarks that great care is to be exercised in making an anatomical diagnosis in such cases, seeing that autopsies have shown various anatomical possibilities with the same clinical phenomena. For not only have progressive palsies of the cerebral nerves been observed without any anatomical lesion (Eisenlohr, Oppenheimer), but they have also been occasioned by peripheral neuritic processes, basal neoplasms of various kinds, disturbances of the nuclei, degeneration of the nerve tracts by sclerotic foci in the course of the intermedullary nerve roots, and, lastly, in a combination of such processes. By far the most frequent cause of double palsy of the oculomotor nerves, especially in syphilis, is involvement of the nerves at the base ; the involvement of the olfactory points the same way in the case reported. On the other hand, lues is quite uncertain in this case. The former abuse of alcohol may be a concurrent cause. The total palsy of the taste introduces a disturbing element. If we agree with Mauthner, the fact of binocular pupillary fixation and paresis of the accommodation already noted in April, is decisive for the diagnosis of nuclear palsy, for at that time a pure almost perfect ophthalmoplegia interna was present on the right side. The absence also of marked general cerebral phenomena and disturbance of the intellect likewise speaks loudly for the involvement of the nuclei (Mauthner). According to Bernheimer, however, the fibres of the oculomotor remain separate, extra nuclear to their exit from the brain, so that ophthalmoplegia interna does not with absolute certainty establish the diagnosis of nuclear palsy. Considering Wesphal-Siemerling's observations this case seems most likely to be a combination of nuclei and nerve degeneration.

A certain prognosis is hardly to be made. The present condition reminds one of Heinrich Heine's malady ; but whether, as in the case of the poet, progressive muscular atrophy is to follow or whether the present palsies are the antecedents of a psychosis, as is often observed, and which are to be feared from the psychical changes which have lately arisen, or whether the process, whatever may be its nature, will extend to neighboring nuclear or nerve regions, or whether it can be arrested by potassium iodide—all this is beyond our ken.

Attention is called to a striking symptom, viz., monolateral innervation of the oculomotor nerve. The patient has complete bilateral ptosis. In spite of this he is able in varying degree to lift the right upper lid sufficiently to see with the right eye, but not through innervation of the levator palpebræ superioris, but by drawing up the right eyebrow and therewith the lid. If the eyebrow be fixed by pressure of the finger at the edge of the orbit, the right lid hangs as limp and smooth as the left. Mauthner first called attention to this symptom in cases of ptosis of longer duration after he had himself acquired complete ptosis on the right side through a trauma. He was able to innervate the right half of the occipitofrontalis alone, and thus to raise the lid. After recovery the power of such innervation was again lost. It is noteworthy in the case here reported that he raises only the right eyebrow, although he is affected with double ptosis. This, however, is very advantageous for him, since double images would at once appear in consequence of the strong divergence of the eye if both lids were raised. It is an interesting circumstance that the patient is unable to maintain monolateral innervation of the facial if the left lid is passively lifted. It shows plainly that the double images thus arising inhibit the subconscious purpose of raising the lid. Mauthner had already observed in himself that the monocular innervation was not under the control of his will, but followed as soon as he opened the left eye (the ptosis was on the right side), although its continuance was unpleasant.

For the comprehension of the phenomenon two facts recently discussed may be brought to mind: Bell's phenomenon (lifting of the eyeball during energetic contraction of the orbicularis) and the orbicularis reaction of the pupil; whereas in both of these cases an overflow of a strong nerve impulse manifestly takes place from the branches of the facial to those of the oculomotor, the opposite occurs in Mauthner's phenomenon. The (palsied) levator palpebrarum is to be innervated. As this does not react, the innervation is strengthened as much as possible until it overflows upon the facial of the forehead. The monolateral innervation is not affected on the left side, probably because the right eye was the one which became diseased last. The anatomical basis of the phenomenon may be most easily understood upon the assumption (still *sub judice*) which Mendel has made from his observation upon animals, that the ocular facialis (frontal and orbicular branch) has its nucleus in the posterior portion of the region of the oculomotor nucleus.

[NOTE. Following Remak's suggestion, electrical excitation of the levator palpebræ superioris was tried, but without result, because the irritation occasioned reflex closure of the lids, which concealed any contraction of the levator which may have existed. The term "monolateral" innervation of the frontalis is moreover not quite correct for the case reported. The muscle is innervated bilaterally, but more strongly on the right side, especially so in its temporal portions, so that the eyebrow with the upper lid is only lifted on the right side.—ED.]

DERMATOLOGY.

UNDER THE CHARGE OF

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Remarkably Sudden and Complete Loss of Beard and Hair of Scalp, followed by Improved Vision.—J. R. CLARKE, of Marion, Kentucky (*American Practitioner and News*, July 15, 1901), reports the case of a man, aged eighty-six years, of fine constitution, and with a history of almost uninterrupted good health until ten years ago, when he was attacked with hæmoptysis, which continued frequently until one year ago; he was often expected to die from exhaustion following the great loss of blood, but at no time were there any pyrexic symptoms nor complications. He arose one morning feeling as well as usual, and after washing his face and combing his hair, ate breakfast, went into the sitting-room, began reading, and became so interested that when his wife asked him to get ready for dinner he was much surprised, as he did not think it possible for the time to pass so rapidly. He went to the mirror to comb his hair and beard, the latter being thick and long, covering the upper portion of his chest. Finding the beard somewhat tangled, he parted it with the fingers. He dined as usual, not thinking of the beard, until his wife inquired what ailed his beard; he replied, "Nothing," but on grasping it in his hand, to his astonishment, it parted without sensation from his face, and he held it in his hand. Going to the mirror he found that the hair was everywhere else loose and falling, including the scalp, and by simply rubbing with the hand it all suddenly and easily came out. In a few days all the hair had disappeared from the entire surface of the body. A short time after losing the hair, the eyesight began to improve very remarkably, there was no more hæmoptysis, and the general health also improved in a marked degree.

[Lest some reader possibly may be disposed to discredit the accuracy of this history, it may be stated that similar cases, *as regards the sudden falling of the hair*, have from time to time been recorded. The improved state of the eyesight following the loss of hair is a most interesting observation, and serves as a valuable lesson, demonstrating the important relation of one part of the general economy to another in many obscure pathological conditions.—EDS.]

Pigmentation of the Skin Caused by the Demodex Folliculorum.—DUBREUILH (*Journal de Médecine de Bordeaux*, 1901, No. 4) calls attention to the fact that the demodex, while usually a harmless occupant of the follicles, when it exists in great number, may give rise to abnormal pigmentation, as shown in the following case under his observation: A woman, aged forty years, brunette, had noticed for several years a fawn-colored discoloration around the mouth extending along the border of the jaws from one angle to the other. This discoloration was not accompanied by itching or inflammation. Upon close inspection the skin was found to be slightly wrinkled and roughened. Similar but less marked pigmentation existed upon the lateral and anterior parts of the neck and upon the chest. Upon examining scrapings from the affected parts with the microscope the demodex was found in extraordinary abundance. The author refers to similar cases observed by Amicis and Majocchi.

The Etiology of Lupus Erythematosus.—POOR (*Dermatologische Zeitschrift*, April, 1901) considers at length the principal arguments urged in favor of the tuberculous origin of lupus erythematosus. He does not find, as has been asserted by other authors, that this affection occurs most frequently in those the subjects of tuberculosis or with a distinct tuberculous family history. The local and general reaction which follows tuberculin injections in lupus erythematosus only occurs irregularly, and cannot be regarded as certain evidence of its tuberculous nature. The presence of giant cells cannot be regarded as proof of the tuberculous character of the disease, since these are found in other diseases which are in no way related to tuberculosis. The occurrence of forms transitional between lupus vulgaris and lupus ery-